SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

May 7, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	**Department**
4265	**Department of Public Health—*Items for Vote Only***
4300	**Department of Developmental Services—*Selected Issues***

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Public comment is welcomed.

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I. Items for "Vote Only" (Page 2 to 3))

A. Department of Public Health

1. Department's Correction for Genetic Disease Screening Program

Budget Issue. The Department of Public Health (DPH) has submitted a Spring Finance Letter to correct a technical adjustment for the Genetic Disease Screening Program. Specifically, the DPH requests an increase of $437,000 (Genetic Disease Testing Fund) to restore the base funding level for 2009-10 that was inadvertently deleted by the DPH when they were creating a new local assistance item for the program.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this technical adjustment and funds from the Genetic Disease Testing Fund are available for this correction.

It is recommended to approve the Spring Finance Letter.

2. California Electronic Death Registration System

Budget Issue. The DPH is requesting a *net reduction* of $212,000 (Health Statistics Special Fund) and to permanently establish 9 state positions to finalize the implementation of the California Electronic Death Registration System.

Specifically, 13 limited-term positions are set to expire as of June 30, 2009. The DPH wants to establish 9 of these positions as permanent to continue the work originally required by the 13 positions. The DPH notes that there are sufficient funds in the Health Statistics Fund to support the positions.

This staff is needed for a variety of functions, including oversight and management of the electronic death registration process, user account maintenance, cross-matching births and deaths for health and security purposes, compiling and disseminating statistical data, and training users of the system.

The DPH contends these positions are necessary in order to provide death data to the public, local agencies, and the state and federal governments.

Background—California Electronic Death Registration System. This system is used to register 98 percent of all deaths in California. The system is presently being used by over 4,000 users, including funeral homes, coroners, medical examiners, physicians, Local Registrars, Health Officers and many others. The system is being expanded to cover all Local Registrars and hopes to have this accomplished by June, 2010.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this adjustment. It is recommended to approve the Finance Letter.

3. Enterprise-Wide Online Licensing Project

Budget Issue. The DPH is requesting an increase of $174,000 (Safe Drinking Water State Revolving Fund) and two positions (two-year limited-term) to conduct the department's Enterprise-Wide Online Licensing Project. This is the second year funding request for this project.

Use of this project for the DPH's Drinking Water Program will enable the program to establish new data collection process both for contract data and permitting process data. It will provide an electronic forum for the request, generation, and issuance of water system permits and all related activities.

Background—Enterprise-Wide Online Licensing Project. There are five programs within the DPH which are participating in this online project that are subject to licensing, enforcement and billing. Many of these program areas various application and operating structures for collecting fees and maintaining data. As such, a more comprehensive system is being developed and implemented. This project will enable the DPH to consistently receive and review applications for initial licenses and renewals, and to oversee services provided under this licensure for adherence to governing laws and regulations.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Subcommittee staff has raised no issues with this adjustment. It is recommended to approve the Finance Letter.

B. Department of Developmental Services

1. Trailer Bill Language to Extend the Adult Residential Facilities for Persons with Special Health Care Needs Pilot ("SB 962" Homes)

Budget Issue. The DDS has proposed trailer bill language requesting a one-year extension of the sunset date for this residential pilot program and its associated report on outcomes. Specifically, the language extends the independent evaluation for the program until January 1, 2010, and extends the residential pilot program until January 1, 2011.

Background--"SB 962" Homes. Senate Bill 962 (Chesbro), Statutes of 2005, directed DDS to establish a new pilot residential project designed for individuals with special health care needs and intensive support needs. Examples of health services that can be provided in this type of home include, but are not limited to, nutritional support; gastrostomy feeding and hydration; renal dialysis; and special medication regimes including injections, intravenous medications, management of insulin, catheterization, and pain management. Nursing staff will be on duty 24-hours per day.

This pilot is a joint venture with the Department of Social Services (DSS) and will serve up to 120 adults, with no more than five adults residing in each facility. This pilot is to be limited to individuals transitioned from Agnews Developmental Center.

Subcommittee Staff Comment and Recommendation. No issues have been raised regarding this extension. It is recommended to adopt the trailer bill language.

II. Items for Discussion-- Department of Developmental Services--

A. OVERALL BACKGROUND (Pages 4 to 7)

Purpose and Description of Department. The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers (RC) ***and*** in state Developmental Centers (DC) for persons with developmental disabilities as defined by the provisions of the Lanterman Developmental Disabilities Services Act. Almost 99 percent of consumers live in the community, and slightly more than one percent live in a state-operated Developmental Center.

To be eligible for services, the disability must begin before the consumer's 18th birthday; be expected to continue indefinitely; present a significant disability; and be attributable to certain medical conditions, such as mental retardation, autism, and cerebral palsy.

The purpose of the department is to: **(1)** ensure that individuals receive needed services; **(2)** ensure the optimal health, safety, and well-being of individuals served in the developmental disabilities system; **(3)** ensure that services provided by vendors, Regional Centers, and the Developmental Centers are of high quality; **(4)** ensure the availability of a comprehensive array of appropriate services and supports to meet the needs of consumers and their families; **(5)** reduce the incidence and severity of developmental disabilities through the provision of appropriate prevention and early intervention service; and **(6)** ensure the services and supports are cost-effective for the state.

Description and Characteristics of Consumers Served. The department annually produces a Fact Book which contains pertinent data about persons served by the department. As noted below, individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes (various models) that are designed to meet their medical and behavioral needs.

Department of Developmental Services—Demographics Data from 2008

Table 1 **Age**	**Number of Persons**	**Percent of Total**	***Table 2*** **Residence Type**	**Number of Persons**	**Percent of Total in Residence**
Birth to 2 Yrs.	26,559	12.4	Own Home-Parent	156,204	72.6
3 to 13 Yrs.	59,643	27.7	Community Care	26,744	12.4
14 to 21 Yrs.	36,989	17.2	Independent Living /Supported Living	18,802	8.7
22 to 31 Yrs.	30,716	14.3	Skilled Nursing/ICF	8,811	4.1
32 to 41 Yrs.	22,163	10.3	Developmental Center	2,891	1.3
42 to 51 Yrs.	21,229	9.9	Other	1,594	0.7
52 to 61 Yrs.	12,157	5.7			
62 and Older	5,590	2.6			
Totals	***215,046***	***100.0***	***Totals***	***215,046***	***100.0***

<u>Background on Regional Centers (RCs)</u>. The DDS contracts with 21 not-for-profit Regional Centers (RCs) which have designated catchment areas for service coverage throughout the state. The RCs are responsible for providing a series of services, including case management, intake and assessment, community resource development, and individual program planning assistance for consumers.

RCs also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. Generally, RCs pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are "generic" services because the RC does not directly purchase these services.

RCs purchase services such as **(1)** residential care provided by community care facilities; **(2)** support services for individuals living in supported living arrangements; **(3)** Day Programs; **(4)** transportation; **(5)** respite; **(6)** health care; and many other types of services.

Services and supports provided for individuals with developmental disabilities are coordinated through the *Individualized Program Plan (IPP) (or the Individual Family Service Plan if the consumer is an infant/toddler 3 years of age or under)*. The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental Center. Services included in the consumer's IPP are considered to be entitlements (court ruling).

In addition, as recognized in the Lanterman Act, differences (to certain degrees) may occur across communities (Regional Center catchment areas) to reflect the individual needs of the consumers, the diversity of the regions which are being served, the availability and types of services overall, access to "generic" services (i.e., services provided by other public agencies which are similar in charter to those provided through a Regional Center), and many other factors. This is intended to be reflected in the IPP process.

<u>Background on State-Operated Developmental Centers.</u> State Developmental Centers (DCs) are licensed and federally certified as Medicaid providers via the Department of Health Services. They provide direct services which include the care and supervision of all residents on a 24-hour basis, supplemented with appropriate medical and dental care, health maintenance activities, assistance with activities of daily living and training. Education programs at the DCs are also the responsibility of the DDS.

The DDS operates five Developmental Centers (DCs)—Agnews, Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition, the department leases Sierra Vista, a 54-bed facility located in Yuba City, and Canyon Springs, a 63-bed facility located in Cathedral City. Both of these facilities provide services to individuals with severe behavioral challenges.

<u>Background—Transitioning to Community Services.</u> The population of California's Developmental Centers has decreased over time. The development of community services as an alternative to institutional care in California mirrors national trends that support the development of integrated services and the reduced reliance on state institutions.

The implementation of the Coffelt Settlement agreement resulted in a reduction of California's Developmental Center population by more than 2,320 persons between 1993 and 1998. This was accomplished by creating new community living arrangements, developing new assessment and individual service planning procedures and quality assurance systems.

The United States Supreme Court decision in *Olmstead v L.C., et al (1999)* stated that services should be provided in community settings when treatment professionals have determined that community placement is appropriate, when the individual does not object to community placement, and when the placement can reasonably be accommodated.

Summary of Budget Appropriation for the Department of Developmental Services.
The February budget package provides a total of $4.645 billion ($2.778 billion General Fund) for 2008-09, and $4.824 billion ($2.726 billion General Fund) for 2009-10 for the Department of Developmental Services (DDS). This reflects an overall increase of $179 million (total funds) from the revised current year.

As shown in the Table below, the Developmental Centers Program is $689.5 million (total funds) for 2009-10. The Developmental Centers Program reflects the *closure* of Agnews Developmental Center in San Jose, as well as other cost-containment measures in the Developmental Centers which have been enacted over the past several years, including furloughs, reductions to operating expenses, staffing adjustments, and budget balancing reductions. According to the DDS, about $124.8 million ($72.5 million General Fund) has been reduced in 2008-09.

Summary of Budget for Department of Developmental Services

Program Component	2008-09 Revised Total Funds	2009-10 February Total Funds	Difference
Community Services	$3,888,239,000	$4,096,986,000	$208,747,000
Developmental Center Program	$719,485,000	$689,457,000	-$30,028,000
Headquarters Support	$37,992,000	$38,265,000	$273,000
TOTAL, All Programs	**$4,645,716,000**	**$4,824,708,000**	**$178,992,000**
Funding:			
General Fund	$2,778,543,000	$2,726,413,000	-$52,130,000
Health & Human Services Fund *(Proposition 10 Funds)*	0	265,000,000	265,000,000
Title XX—Social Services Grant	203,903,000	228,173,000	24,270,000
Public Transportation Fund	138,275,000	138,275,000	0
Program Development Funds	1,855,000	1,912,000	57,000
Federal Funds	90,829,000	54,093,000	-36,736,000
Mental Health Services Fund	1,119,000	1,121,000	2,000
Developmental Services Account	75,000	0	-75,000
Lottery Education Fund	495,000	0	-495,000
Reimbursements (Various)	$1,430,622,000	$1,409,721,000	-20,901,000
Regional Center Consumers	229,675	242,520	12,845
Developmental Center Residents	2,404	2,279 (as of April)	-125

The Community Services (funds provided primarily to Regional Centers) appropriation is about $4.1 billion (total funds) for 2009-10. This appropriation reflects the following *key* adjustments:

- Restoration of $234 million (General Fund) provided by the Legislature to offset the $334 million (General Fund) reduction proposed by the Governor (i.e., resulting in a $100 million General Fund reduction).
- Reflects a 3 percent payment reduction of Regional Center providers for a reduction of $118.2 million ($72.4 million General Fund) as proposed by the Governor.
- A fund shift of $265 million (General Fund) to the Health & Human Services Fund (Proposition 10 Funds of 1998) for the Early Start Program within the DDS. This fund shift is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.
- Continues all cost-containment enacted for the past several years.

Medi-Cal Optional Benefits for Individuals with Special Needs. As proposed by the Governor, certain Medi-Cal Optional Benefits were *not* funded in the February budget package, nor was the trigger activated as specified to restore these services, including Adult Dental, Optical Labs, Optometrists/Opticians, Chiropractor, Psychologist services, Podiatrist, Acupuncturist, Audiologist and Incontinence Creams and Washes. This action reduced Medi-Cal by about $129 million in General Fund support. As has been previously discussed in the Subcommittee, elimination of these benefits is an extremely difficult action.

The DHCS states they have accounted for potential cost-shifts to other services, such as emergency room usage; however, no one knows the potential consequences to enrollees or the health care safety net since this has never previously occurred.

However, an increase of $8.2 million (General Fund) will be needed in the Department of Developmental Services to continue to provide these services through the Regional Center system. This will be discussed at the May Revision.

Budget Act Language—Allows for Transfer Between Items. Finally, it should be noted that the annual Budget Act contains Budget Act Language which provides for the transfer of funds as necessary between the Developmental Centers Program and the Community Services appropriation (See provision 3 on page 335 of Senate Bill 1, Statutes of 2009). The purpose of this language is to enable the DDS to transfer funds, as appropriate, for individuals transitioning from a Developmental Center to the community.

B. Issues for Discussion: Results of Joint DDS& Stakeholder Process

Background-- Overall Budget Issue and the $100 million. In the Governor's January budget, the Administration proposed to reduce the Department of Developmental Services' (DDS) allocation for the Regional Centers by $334 million (General Fund). Specifically, the Administration stated that: "The DDS Regional Centers continue to experience significant and unsustainable expenditure growth. The DDS will work with the Legislature and stakeholders in the coming months to develop proposals to maintain the 2008-09 fund level and achieve the targeted savings while maintaining the entitlement and ensuring program and service integrity." (Pages 30 and 31 of the Governor's Budget 2009-10 publication.)

In lieu of the Administration's proposal to reduce by $334 million (General Fund), the Legislature *increased* the Regional Center budget by $234 million (General Fund) and adopted trailer bill language, as contained in AB 3X 5 (Evans), Statutes of 2009 (See Section 10). Therefore, a reduction of $100 million (General Fund) was enacted. Now a specific plan on how to achieve this was necessary.

The trailer bill legislation directed the DDS to submit a Plan to the Legislature that shall identify specific cost containment measures to achieve $100 million (General Fund) in reductions in 2009-10, instead of the Governor's original proposal to reduce by $334 million (General Fund). This Plan is to include a comprehensive description of each proposal, any applicable comment from the department and stakeholders as deemed appropriate by the department, its General Fund savings, and draft statutory language necessary to implement each proposal, and its potential effect on the developmental services system.

A key aspect of the legislation was to direct the DDS to use a comprehensive "stakeholder process" to include statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations, as well as staff from the Legislature, to craft the components of the Plan.

Finally, the legislation also contained a provision that in the event statutory changes are *not enacted by September 1, 2009* to achieve the $100 million (General Fund) reduction for 2009-10, the DDS shall direct Regional Centers to reduce most payments for services and supports (as specified in Section 10) provided on or after September 1, 2009, by 7.1 percent. To the extent that statutory changes are enacted at a later date to produce a portion of the $100 million reduction amount, then the 7.1 percent reduction may be reduced accordingly. This language was added in order to ensure that a mechanism exists to achieve the reduction.

Background—Stakeholder Processes. The DDS used three processes to obtain public information to craft the Plan. First, DDS convened three public forums in Sacramento, Oakland, and Los Angeles. In total, about 1,400 stakeholders participated in these forums. Second, the DDS participated in a California Disability Community Action Network town hall meeting and received over 1,350 written recommendations outlining budget suggestions.

Third, the DDS convened focused "Workgroup" meetings to discuss proposals with representatives from statewide groups impacted by the reductions. These Workgroup meetings were very involved and required immense commitment by the representatives from the statewide groups as well as the DDS. All involved parties should be commended for their constructive efforts under extremely difficult circumstances with this fiscal crisis.

Summary Chart of DDS & Workgroup Proposal for $100 million (General Fund)

Name of Proposal	TBL or Reg?	2009-10 Total Savings (GF Savings)	Annual Savings
1. Transportation reform	Both	$18.4 million **($16.9 million GF)**	$39.9 million **($36.6 million GF)**
2. Uniform holiday schedule	TBL	$22 million **($16.3 million GF)**	$22 million **($16.3 million GF)**
3. Create a new program component for seniors	TBL	$1.4 million **($1 million GF)**	$1.4 million **($1 million GF)**
4. Custom Endeavors Options	TBL	$17.1 million **($12.7 million GF)**	$17.1 million **($12.7 million GF)**
5. Maximizing Generic Resources in Supported Living	TBL	$1.9 million **($1.3 million GF)**	$1.9 million **($1.3 million GF)**
6. Amend Support Living Services	Both	$10.5 million **($6.9 million GF)**	$21 million **($13.8 million GF)**
7. Utilization of Neighborhood Preschools	TBL	$8.9 million **($8.9 million GF)**	$17.8 million **($17.8 million GF)**
8. Early Start--Access Private Insurance (0-3 years)	TBL	$6.5 million **($6.5 million GF)**	$13 million **($13 million GF)**
9. Early Start--Restrict eligibility for low risk	TBL	$15.5 million **($15.5 million GF)**	$15.5 million **($15.5 million GF)**
10. Change the duties of some respite workers	Both	$4 million **($3 million GF)**	$4 million **($3 million GF)**
11. Cap Regional Center operations for one-time costs	--------	$3.5 million **($3.5 million GF)**	$3.5 million **($3.5 million GF)**
12. Eliminate Regional Center Triennial Review	Both	$1.5 million **($1 million GF)**	$1.5 million **($1 million GF)**
13. Update Parental Fee Program	Both	$900,000 **($900,000 GF)**	$2.2 million **($2.2 million GF)**
14. Consolidate Quality Assurance Evaluation	TBL	$2 million **($2 million GF)**	$2.2 million **($2.2 million GF)**
15. First Use “Group Instruction” for Behavioral Instruction	TBL	$8.1 million **($6.4 million GF)**	$16.2 million **($12.8 million GF)**
TOTAL		$122.2 million **($102.8 million GF)**	$179.2 million **($152.7 million GF)**

B. Issues for Discussion: Results of DDS & Workgroup Process *(Continued)*

Of key importance to the DDS and Workgroup was to identify proposals with the least adverse impact on the consumer while still ensuring program and service integrity. Other goals included maximizing the use of generic resources pursuant to the Lanterman Developmental Disabilities Services Act, and maximizing receipt of federal funds.

Each of the 15 proposals is discussed below. The Subcommittee has requested the DDS, and Workgroup participants to respond to questions as noted under *each* of the proposals below. Overall public comment will then be obtained on all of the proposals. Everyone's public comments are welcomed. Written comments are also welcomed.

1. Transportation Reform (See Trailer Bill Hand Out—Section 10)

Background. Regional Centers purchase transportation services for over 56,000 consumers annually. These purchased services include specialized transportation, vouchers, taxis, bus passes for public transportation, and services provided by Day and Residential programs as an additional component of their vendored service. Transportation is provided so consumers can attend Day Programs, Infant Development Programs, therapies and medical care, social-recreation activities, work, and other daily activities.

It is estimated that Regional Centers would spend about $239 million (total funds) for transportation services in 2009-10, absent this reduction proposal. Of this total amount, about $100 million is based on contracted transportation services.

Summary of Proposal. The intent of this proposal is to increase the use of "generic" and least costly transportation methods.

Under this proposal, at the time of development, scheduled review or modification of a consumer's Individual Program Plan (IPP) or Individual Family Service Plan (IFSP), Regional Centers would be directed to:

- No longer fund *"specialized"* transportation services for *adults* who can *safely* access and utilize public transportation, *when such transportation is available*;
- Only fund the *least* expensive transportation modality that meets the consumer's needs as set forth in the consumer's IPP or IFSP;
- Fund transportation, when required, from the consumer's residence to the lowest cost vendor (program) that provides the service that meets the consumer's needs; (lowest cost here means the cost of the vendor and transportation)
- Only fund transportation services for minor children when the family provides documentation that they cannot provide transportation themselves.

This proposal is estimated to result in a reduction of $18.4 million ($16.9 million General Fund) in 2009-10, with an annualized savings of $39.9 million ($36.6 million General Fund).

This savings level assumes that about 10,000 consumers, or about 28 percent of the estimated 36,000 consumers who may be affected by the proposal, will move from a higher cost type of transportation to a lower cost method of transportation over the course of the year.

This proposal requires trailer bill legislation, regulation changes and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program as administered by the DDS).

Subcommittee Staff Comment and Recommendation. This proposal seems reasonable as a cost savings measure and would not adversely impact consumers since it would be contingent upon their IPP or IFSP and their needs. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

2. Uniform Holiday Schedule (See Trailer Bill Hand Out—Section 18)

Background and Summary of Proposal. The intent of this proposal is to increase the number of uniform holidays to a *total of 14 specific* days in order to achieve savings across the various Day Programs, Work Programs, *and* associated transportation costs to and from these programs.

This proposal is estimated to result in a reduction of $22 million ($16.3 million General Fund) in 2009-10, with annualized ongoing savings of the same amount.

Under this proposal, trailer bill language would be adopted which states that Regional Centers shall *not compensate* any work activity program, activity center, adult development center, behavior management program, social recreation program, adaptive skills trainer, infant development program, program support group (day service), socialization training program, client/parent support behavior intervention training program, community integration training program, community activities support service, or creative arts program, as defined in Title 17 of the California Code of Regulations, for providing any services to any consumer on any of the specified, uniform holidays. Monday holidays would be observed in the event a specified holiday falls on a Saturday or Sunday.

The uniform holidays would include the following: (1) January 1; (2) the third Monday in January; (3) the third Monday in February; (4) March 31st; (4) the last Monday in May; (5) July 4th; (6) the first Monday in September; (7) November 11th; (8) Thanksgiving Day; (9) December 25th; and (10) the *four days between December 25th and January 1st*.

The effect of this proposal is that on these uniform holiday days, consumers will either be with their family, friends, or if they live in an out-of-home placement they would be with the residential provider.

Presently the 21 Regional Centers have slightly varying holiday schedules. The DDS states that: (1) six Regional Centers have 12 holidays; (2) eleven Regional Centers have 10 days; and (3) four Regional Centers have less than 10 days.

Subcommittee Staff Comment and Recommendation. *First*, this proposal would have less impact on consumers than potentially other proposals. *Second*, this proposal would affect residential providers since the consumer (i.e., consumers living out-of-home) would not be participating in any of various day programs as referenced, and instead, maybe staying home. However, many of these consumers would be with family and friends during a portion of this “traditional” holiday time. *Third*, it would affect various day program providers as referenced since the added holidays would, in effect, serve as “furlough time”. It is recommended to hold this issue “open” to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

3. Create a New Program Component for Seniors at a Reduced Rate
(See Trailer Bill Hand Out—Section 14)

Background and Summary of Proposal. Presently, consumers participate in various Day Programs (including look-alike) and Work Activity Programs. These programs are based on a staff to consumer ratio grounded in providing specific activities and services. Generally, reimbursement for these providers is based on the staffing ratios and types of services provided.

The intent of this proposal is that some consumers presently participating in these programs would want to "retire" or participate in less intensive services. Under the proposal, a new program component for seniors, or individuals desiring a less rigorous Day Program, would be created as an alternative choice. This new program component would be reimbursed at a reduce rate and would have a *lower* staff to consumer ratio of 1 to 8 (as compared to a 1 to 3, 1 to 4, or 1 to 6).

To achieve savings, the rate of reimbursement would be reduced from as high as $72.42 per day and as low as $35.34 per day (i.e., the existing range) down to $35 per day due to the lower staffing ratio and less intensive program.

This proposal is estimated to result in a reduction of $1.4 million ($1 million General Fund) in 2009-10, with annualized ongoing savings of the same amount. This savings level assumes five percent of adults served in the programs referenced would prefer this new program component, and that providers are reimbursed at the $35 per day level.

It should be noted that providers would be required to offer this alternative (i.e., has to be in their existing vendored capacity) or savings would not be achieved.

Selection of this alternative program component would be based on a consumer's IPP.

Subcommittee Staff Comment and Recommendation. This proposal creates a new program component that offers additional consumer choice, based upon their IPP. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

<u>4. Custom Endeavor Option (See Trailer Bill Hand Out—Section 15)</u>

<u>Background and Summary of Proposal.</u> The DDS states that about 51,000 consumers are served by Day Programs (including look-alikes) annually and receive about 120 hours per month of services.

Some of these consumers often want to work, volunteer or become self-employed. The intent of this proposal is to provide a customized employment or volunteer option with support from existing providers for 5 percent of the current consumers. This would increase consumer independence and choice of activities.

Under this proposal, a provider would offer this customized program component to a consumer in lieu of their current program. This alternative would be based on a consumer's IPP.

This proposal is estimated to result in a reduction of $17.1 million ($12.7 million General Fund) in 2009-10, with annualized ongoing savings of the same amount. This savings level assumes that 5 percent of current consumers will opt out of their existing Day Program and select this alternative. Of those which choose this alternative, half of the consumers will receive 20 hours of services per month and the other half will receive 80 hours of services per month.

The Day Programs affected by this option include: (1) Community Integration Training; (2) Community Activities Support Services; (3) Activity Center; (4) Adult Development Center; and (5) Behavior Management Program.

<u>Subcommittee Staff Comment and Recommendation.</u> This proposal creates a new program component that offers additional consumer choice, based upon their IPP. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

<u>Questions.</u> The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

5. Maximizing Generic Resources in Supported Living
(See Trailer Bill Hand Out—Sections 16 & 17)

Background—Generic Services. Regional Centers purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. Generally, Regional Centers pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called “generic” services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are “generic” services because the Regional Center does not directly purchase these services.

Background—Supported Living Services (SLS). Supported Living Services consist of a broad range of services to adults with developmental disabilities who, though the Individual Program Plan (IPP) process, live in homes they themselves own, rent, or lease in the community.

Background—IHSS Services for Consumers in Supported Living Arrangements. DDS states that about 10,909 Regional Center consumers currently receive In-Home Supportive Services (IHSS).

From the time a consumer applies for IHSS services to the time their application is approved, domestic “personal care services” are purchased through the Regional Center in order for consumers to maintain living in a “Supported Living” arrangement. The amount of time between applications to approval (i.e., a “lag period”) *varies from one to three months.* Reimbursement for these services should be made from the IHSS Program at the local county level.

Currently during this “lag period”, the DDS is paying a *higher rate* to the Supported Living Service provider than it would if the consumer were enrolled in IHSS. Once IHSS is approved, the Supported Living Service provider no longer provides the “personal care services”, and the IHSS provider takes over at the IHSS rate (along with a county share-of-cost).

Payment for the “lag period” is at issue. The Department of Social Services’ policy is that county IHSS offices will reimburse only “out-of-pocket” expenses incurred in this period, referring to what is paid directly by the consumer for “like” services. In actuality, the consumer does not pay out of pocket for services due to California’s service delivery model with funding for all services coming through the Regional Center. *Therefore, Regional Centers are not getting reimbursed for the “lag period” (waiting period).*

Summary of Proposal. The intent of this proposal is to maximize the use of *generic* IHSS services. There are two key aspects to this proposal. *First*, In addition, the DDS proposes that during the “lag period” (waiting for IHSS enrollment), personal care services (i.e., “like services”) would only be reimbursed at the local IHSS rate and not at the higher Supported Living Services rate

Second, Regional Centers will be *prohibited* from purchasing “personal care services” for consumers who are Medi-Cal enrollees and are therefore eligible for IHSS. This is because there is a small number of consumers that do not apply for IHSS and could be eligible. Due to fiscal constraints, this generic service needs to be maximized.

This proposal is estimated to result in a reduction of $1.9 million ($1.3 million General Fund) in 2009-10, with annualized ongoing savings of the same amount.

Subcommittee Staff Comment and Recommendation. The Administration, including all of the health and human services departments, need to provide more comprehensive assistance to the Regional Centers and consumers in order to more fully and appropriately maximize the use of "generic" services prior to the "purchasing" of services. The intent of this proposal is a step in that direction, but the trailer bill language needs to be carefully constructed to ensure the correct intent of this action.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

6. Amend Existing Supported Living Services (See Trailer Bill Hand Out---Section 16)

Background—Supported Living Services (SLS). Supported Living Services consist of a broad range of services to adults with developmental disabilities who, though the Individual Program Plan (IPP) process, live in homes they themselves own, rent, or lease in the community. About 10,000 individuals use Supported Living Services at a cost of about $300 million (total funds) annually.

Summary of Proposal. Under this proposal, several changes would be made in how supported living services are funded. *Key* changes are as follows:

- Requires Regional Centers to review and re-negotiate rates with Supported Living Services Agencies as specified.
- Restricts conditions under which Regional Centers can supplement a consumer's rent, mortgage, or lease payment.
- Requires Regional Centers, where applicable and appropriate, to use the same Supported Living Services Agency to provide services that meet individual consumer's needs as determined through the IPP process, of consumers who reside in the same home.

This proposal is estimated to result in a reduction of $10.5 million ($6.9 million General Fund) in 2009-10, with annualized ongoing savings of $21 million ($13.8 million General Fund).

This proposal requires trailer bill legislation, regulation changes and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program as administered by the DDS).

Subcommittee Staff Comment and Recommendation. This is a complex proposal that may require additional clarification as to how it would be implemented. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

7. Utilization of Neighborhood Preschools (See Trailer Bill Hand Out—Section 12)

Summary of Proposal. The intent of this proposal is to expand the availability and use of neighborhood preschools as a natural environment which may be less costly than segregated center-based Infant Development Programs.

The DDS estimates that increased use of Preschool programs would save $8.9 million (General Fund) in 2009-10, and $17.8 million (General Fund) on an annual basis. This savings estimate assumes that *5 percent* of the children, or 1,535 children, served by Infant Development Programs could be served in a neighborhood Preschool Program. The use of a neighborhood Preschool would be based on the child's Individualized Family Service Plan (IFSP).

This savings level assumes that additional resources are provided for an early interventionist or speech therapist to provide specialized early intervention services at the Preschool.

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

According to the DDS, the Frank D. Lanterman Regional Center presently uses this approach for some children receiving services. The Regional Center funds Preschools and Child Care Centers for children in their Early Start Program. The service is listed on the child's IFSP as specialized instruction, a required early intervention service, to address socialization or speech development using typically developing children as role models. Occasionally, individually vendored therapists, primarily a speech therapist, are funded by the Regional Center to provide early intervention services at the Preschool.

The DDS notes that about 60,000 infants and toddlers receive services through the Early Start Program, and about 30,841 children, or over 50 percent, are receiving services through Infant Development Programs. There are 419 Infant Development Programs operating in California.

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

Usually, toddlers begin attending center-based programs (Infant Development Programs) *after* turning 18-months of age. Typically, attendance at an Infant Development Program ranges from two to three times per week for about 3-hours each day. The rates for Infant Development Programs range from about $29 to $48 per day (at a 1 to 3 staff to consumer ratio) to about $43 to $74 per day (at a 1 to 2 ratio).

In some areas of the state, Regional Centers fund social-recreational programs or preschool using the Child Day Care service code at a "usual and customary" or negotiated rate. This results in a rate of from $13 to $25 per hour. These programs are used to enhance social and language development. However, they do not meet the description for specialized instruction or therapeutic services.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Background—Neighborhood Preschools. Generally, neighborhood preschools provide a variety of child care and development programs to young children and youth up to 12 years of age. Preschools may include public and private programs. Specific services and age ranges offered are based on program design.

Preschool programs under the California Department of Education's Child Development Division serve three to five year olds and are state and federally funded. Their rates are based on "usual and customary rates" in each region of the state.

Subcommittee Staff Comment and Recommendation. There are a few Regional Centers who presently use this approach for some children receiving services. The Lanterman Act requires Regional Centers to use generic services when available and when applicable (based on an individual's IFSP or IPP). Adoption of trailer bill language will encourage a more coordinated approach.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

<u>Questions.</u> The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

8. Use of Private Insurance for Early Start Program Consumers
(See Trailer Bill Legislation Hand Out—Section 1)

Summary of Proposal. Under this proposal, families would be required to access private insurance for all identified medical services, *other than* evaluation and assessment, for service provision or denial prior to service provision by a Regional Center as payer of last resort (This is already required for children age three years and older).

The identified medical services include the following: Acute Care Hospital; Durable Medical Equipment Dealer; laboratory and radiological services; other medical equipment supplies; orthopedic services; prosthetic services; pharmaceutical services; physician/surgeon; hearing & audiology facilities; licensed vocational nurse; other medical services; audiology; speech pathology; physical therapy; occupational therapy; and genetic counselor.

Of the total expenditures for the Early Start Program, the DDS estimates that $89.4 million is in medical-related expenditures.

The DDS estimates this change would save $6.5 million (General Fund) in 2009-10, and $13 million (General Fund) on an annual basis. This estimate assumes that 25 percent of medical-related costs for families with insurance coverage are to be covered by insurance. It is assumed that 58 percent of the families have health insurance (based on the CA Health Insurance Survey of 2005).

In situations where the medical service is determined to be not medically necessary, but is developmentally necessary, then the service would be a required early intervention service under federal regulations.

The DDS notes that this proposal complies with existing federal law, and conforms to the state's Lanterman Act which requires Regional Centers to pursue other sources of funding for services (i.e., "generic" services and payer of last resort).

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

Further, DDS states this proposal would be effective as of July 1, 2009 with a phase-in during 2009-10 consisting of dissemination of information to families participating in the Early Start Program and to Regional Centers.

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Background—Department of Managed Health Care Letter *(See Hand Outs)*. In a March 9, 2009 letter, the Department of Managed Health Care notified Knox-Keene health care plans that the DMHC is directing these plans to significantly improve their performance in several areas with respect to providing services for individuals diagnosed with Autism Spectrum Disorders.

Key aspects of this letter are as follows:

- DMHC will be asking health plans to demonstrate that their systems and processes support timely screening and diagnosis of individuals, including mental health services.
- DMHC directs that health plans must assure that treatment plans are developed by qualified and licensed providers, and include information about available health care treatment options.
- DMHC directs that health plans are required to coordinate covered services for the treatment of Autism Spectrum Disorders among their various providers to help implement treatment plans.
- DMHC requires all plans to cover all basic health care services required under the Knox-Keene Act, including speech, physical, and occupational therapies for persons with Autism Spectrum Disorders, when those health care services are medically necessary.

- DMHC states that they will continue to enforce existing law regarding the grievance and Independent Medical Review process and will be initiating a rulemaking process to formalize health plan requirements and provide additional clarity through an open and public process.

Subcommittee Staff Comment and Recommendation. This proposal would *extend* to families with children aged 0 to 3 years the requirement to access private insurance for all identified medical services *other than* evaluation and assessment, for service provision or denial prior to service provision by a Regional Center as payer of last resort.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

9. Early Start Program—Restrict Eligibility for Low-Risk (See Trailer Bill Legislation Hand Out—Section 2)

Summary of Proposal. Under this proposal, eligibility for the Early Start Program would prospectively limit eligibility for Early Start services to only those infants and toddlers at the highest risk of a developmental disability in most need of program services entering Early Start at 24 months of age or older.

This proposal does require trailer bill language, as well as a revision to the state's Early Start Program that will need to be submitted to the federal government.

Specifically, *two changes* would occur under this proposal as follows:

> At Risk. Presently, those determined "at-risk" can enter the Early Start Program at any age (0 to 3 years). Under this proposal, those who are determined "at-risk" *and* are aged 24 months or older would not be eligible for Early Start.
>
> Developmental Delay. Presently, those who have a "developmental delay" of 33 percent or greater in one of five domains can enter into the Early Start Program at any age. Under this proposal, those who have a "developmental delay" in *only* one domain *and* are aged 24 months or older would need to have a "developmental delay" of 50 percent or greater.

Currently, Early Start serves infants and toddlers who are at risk for developmental disability, who manifest established risks for developmental delay, or who have developmental delays in one or more of five domains (cognitive, self-help, physical, communication and social-emotional). Of the 60,000 children served annually in Early Start, about 23 percent enter the Regional Center caseload at age 36 months as *ongoing* Regional Center consumers.

The DDS estimates this change would save a total of $15.5 million (General Fund) in 2009-10, and $15.5 million (General Fund) on an annual basis. Of this total amount, $13.4 million (General Fund) would be reduced from Purchase of Services and $2.1 million (General Fund) would be reduced from Regional Center Operations.

This reduction level assumes the following *key* assumptions:

- It is assumed that for restricting "at risk" eligibility" at 24 months or older there would be a savings of $333,740 from the Purchase of Services. This assumes 205 children out of a total of 244 children in this category would no longer be eligible for services in Early Start.

- It is assumed that for restricting "developmental delay" eligibility at 24 months or older there would be a savings of $13.1 million from the Purchase of Services. This assumes 10,691 children out of a total of 17,174 children in this category would no longer be eligible for Early Start.

  The DDS states that about 93 percent of the children with a delay in one domain only have a speech delay domain (i.e., communication development as referenced in the federal regulation discussion below).

- The reduction of $2.1 million from Regional Center Operations is based on the core staffing formula and ratios and upon a mid-year caseload reduction of 5,346 consumers

The DDS notes that this proposal does not impact the eligibility of any infant or toddler under the age of 24 months, and may result in fewer children transitioning to Regional Center caseloads at the age of 36 months. On the other hand, without early intervention, some infants and toddlers may enter the Regional Center system or special education at an older age.

The DDS also states that other services may be available for children who may no longer be eligible for Early Start services due to this proposal. Families may be able to access private insurance, Medi-Cal, or Head Start for services where applicable.

Background—Existing Federal Regulations. There are two components to federal regulation that pertain to this issue. Part 303.16 of the federal regulations states as follows:

303.16 Infants and Toddlers with Disabilities.
(a) As used in this part, infants and toddlers with disabilities means individuals from birth through age two who need early intervention services because they:
(1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas (This is California's developmental delay definition):

(i) Cognitive development;
(ii) Physical development, including vision and hearing.
(iii) Communication development.
(iv) Social or emotional development
(v) Adaptive development; *or*

(2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. (This is California's "established" risk definition).

(b) The term may also include, at a State's discretion, children from birth through age two who are at risk of having substantial developmental delays if early intervention services are not provided. (This is California's "at-risk" definition).

303.300 State Eligibility Criteria and Procedures.
Each statewide system of early intervention services must include the eligibility criteria and procedures, consistent with 303.16, (above) that will be used by the State in carrying out programs under this part.
(a) The State shall define developmental delay by the following (This is California's developmental delay definition):

(1) Describing, for each of the areas listed in 303.16 (a)(1), the procedures, including the use of informed clinical opinion, that will be used to measure a child's development; *and*

(2) Stating the levels of functioning or other criteria that constitute a developmental delay in each of those areas.

(b) The State shall describe the criteria and procedures, including the use of informed clinical opinion, that will be used to determine the existence of a condition that has a high probability of resulting in developmental delay under 303.16(a)(2). (This is California's established risk definition).

(c) If the State *elects* to include in its system children who are at risk under 303.16(b), the State shall describe the criteria and procedures, including the use of informed clinical opinion that will be used to identify those children. (This is California's "at risk" definition).

Background—the Early Start Program (0 to 3 years) The Early Start Program is administered by the DDS through the Regional Centers, local education agencies, and Family Resource Centers.

The program provides coordinated early intervention services to infants and toddlers (aged 0 to 3 years) and their families with or at-risk for developmental delays or disabilities. The services provided to infants and toddlers are contingent upon their Individualized Family Service Plan (IFSP).

Currently, Early Start serves infants and toddlers who:

- Are At high risk for developmental disability;
- Manifest established risks for developmental delay; or
- Have developmental delays

Early Start provides specialized early intervention services in the home, community and center-based settings through Infant Development Programs by a team of qualified interdisciplinary professionals that often include early interventionists, physical therapists, occupational therapists, and speech and language therapists.

According to the DDS, about 60,000 infants and toddlers are served annually in the Early Start Program. Of these infants and toddlers, about 13,800 (23 percent) enter the Regional Center caseload at 3 years of age as *ongoing* Regional Center consumers.

Background—Early Start Program Budget for 2009-10. The DDS states that the "purchase of services" (POS) for the Early Start Program is about $400.2 million ($50.7 million federal Part C grant funds, $135.2 million General Fund, and $265 million Proposition 10 Health and Human Services Fund)

It should be noted that the $265 million appropriated from the Proposition 10 Health and Human Services Fund is *contingent upon voter approval* of Proposition 1D in the Special Election of May 19, 2009.

It should also be noted that the American Recovery & Reinvestment Act, signed by President Obama in February, 2009, will provide an additional $53.2 million in federal Part C grant funds to California for two years (i.e., $26.6 million for two years). The Governor's May Revision should reflect this change. This issue will be before the Legislature in late May.

Subcommittee Staff Comment and Recommendation. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

10. Modify the Duties of In-Home Respite Workers (See Trailer Bill—Section 13)

Summary of Proposal. The DDS states that many consumers are medically fragile but medically stable and receive respite services from Home Health Agencies or Licensed Vocational Nurses. In some cases, In-Home Agency employees with proper training could provide the respite care in lieu of the Home Health Agency or Licensed Vocational Nurse.

Under this proposal, "In-Home" Respite Agency employees would include certain additional services, *as appropriate*, in their duties. By having In-Home Respite Agency employees perform these services, it is assumed that less respite hours would need to be provided by Home Health Agencies and Licensed Vocational Nurses which are more expensive.

The intent of this proposal is to have non-licensed respite workers provided training by licensed health care professionals to be able to perform incidental medical services as follows:

(1) Colostomy and ileostomy: changing bags and cleaning stoma.

(2) Urinary catheter: emptying and changing bags.

(3) Gastrostomy: feeding, hydration, cleaning stoma, and adding medication per physician's or nurse practitioner's orders for the routine medication of patients with stable conditions.

The draft trailer bill language provided by the DDS states that any consumer who is provided these additional services by an In-Home Respite Agency employee would need to have their treating physician or surgeon give assurances to the Regional Center that the consumer's (patient) condition is stable prior to the Regional Center's purchasing incidental medical services from an In-Home Respite Agency.

This proposal requires trailer bill language, regulation changes and an amendment to the state's Home and Community-Based Waiver (under the Medi-Cal Program).
It assumes savings of $4 million ($3 million General Fund) for 2009-10 and the same amount on an annualized basis. This level of savings assumes the following:

- Reduction of 10 percent in the number of respite hours purchased from Home Health Agencies and Licensed Vocational Nurses.
- Corresponding increase of 10 percent in the number of respite hours purchased through In-Home Respite Agencies.
- Increase of $0.50 per hourly wage (limited to hours providing "skilled" respite services), *plus* a 16.76 percent increase for the employer costs due to the wage increase (for social security, worker's compensation, unemployment compensation), for In-Home Respite Agencies (employees and employer as noted).
- Provides that Regional Centers may reimburse In-Home Respite Agencies up to $200 semi-annually for providing training to its employees for the additional services to be conducted.

<u>Subcommittee Staff Comment and Recommendation.</u> It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

<u>Questions.</u> The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

11. Cap Regional Center Operations for One-Time Costs

Summary of Proposal. Under this proposal, funding for one-time costs associated with certain Regional Center administrative costs would be reduced from $6.5 million (General Fund) to a total of $3.0 million for 2009-10 for a savings of $3.5 million (General Fund).

One-time funding for Regional Centers is used for opening a new branch office, moving expenses, expansion of communication services or other similar expenditures.

This proposal does *not* require any trailer bill legislation or any other related changes.

Subcommittee Staff Comment and Recommendation. Regional Centers will need to prudently manage their one-time costs but otherwise, no issues have been raised.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

12. Eliminate Triennial Quality Assurance Review (See Trailer Bill—Section 9)

Summary of Proposal. Under this proposal, the existing requirement for Regional Centers to conduct quality assurance evaluations to be done a minimum of once every three years would be eliminated. This action would require trailer bill language, a regulation change and a modification to the State's Home and Community Based Waiver (under the Medi-Cal Program).

Under the current "triennial quality assurance review", Regional Centers conduct a detailed review of vendored Community Care Facilities which includes record reviews, consumer observation and interviews to determine satisfaction with facility services, and an assessment of the facility in assisting consumers in achieving their individual life quality outcomes.

The DDS does not believe elimination of this requirement will be problematic because other health and safety reviews will still be conducted as noted in the background section below.

This proposal would save $1.5 million ($1 million General Fund) in 2009-10 and have an annual savings of $1.5 million ($1 million General Fund). The savings results from reduced Regional Center staffing needs.

Background—Overview of Quality Assurance Activities. There are several existing quality assurance functions which are conducted to help ensure the health and safety of consumers in the Regional Center system. These include the following:

- A Regional Center representative must meet at least quarterly with each consumer to review progress towards achieving their Individual Program Plan (IPP) objectives. At least two of these reviews must occur at the consumer's residence and may be unannounced.
- Each Regional Center must designate a liaison for each facility. The RC facility liaison is responsible for completing a minimum of one monitoring visit to each facility each year.
- The DDS and Regional Centers have implemented revised Client Development and Evaluations for consumers which includes a personal outcomes element which includes questions to capture the quality of each consumer's school, work, and living environments.
- The DDS has a monitoring protocol for quality assurance evaluations under the Home and Community-Based Waiver.
- The Department of Social Services conducts annual licensing visits.

Subcommittee Staff Comment and Recommendation. This cost-containment measure seems reasonable given there are other quality reviews and assurances in place. It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

13. Increase the Parental Fee for Out-of-Home Arrangements
(See Trailer Bill Legislation—Section 11)

Summary of Proposal. Under this proposal, the Parental Fee that applies to parents of children under the age of 18 who live in any out-of-home care arrangement (including community-based or a Developmental Center) would be increased and the increase in the fees would be placed into the General Fund. The current Parent Fee was last adjusted in 1989, except for an increase in the maximum fee amount in 2003 which took the fee to $662 (maximum monthly amount).

The DDS states the Parental Fee would be changed in *two ways*. *First*, the minimum income level upon which the fee is based would be updated to be equivalent to 100 percent of poverty, or $18,310 for a family of three. Presently, families at the income level of $12,501 are subject to payment. This action will *decrease* the number of families subject to the fee by about 10 percent.

Second, the fee would be updated across all levels of income and adjusted to reflect the 2007 data available from the U.S. Department of Agriculture's survey on the cost of raising a child in California (adjusting for the consumer price index from the survey date to the present). Parents are assessed a fee based on a sliding scale that varies by family income and family size. The fee is the same regardless of where the child is placed out-of-home.

The Hand Out Package contains a detailed chart on this proposal. to reflect the monthly fee. For some low-income families, no fee would be assessed. The maximum fee may *not* exceed (1) the cost of caring for a normal child at home, or (2) the cost of services provided, whichever is less. The revised maximum amount a family would pay under the proposal would be $1,877 per month for the highest income families with the oldest children.

Some examples of fees from the chart are as follows:

- Family of two with an income of $18,310 would pay a maximum of $75 per month.
- Family of four with an income of $22,050, with one child aged 0 to 6 would pay $116 per month (previously it would be $85 per month).
- Family of three with an income of between $33,000 and $36,999 would pay a maximum of $375 per month.
- Family of three with an income between $45,000 and $48,999 would pay a maximum of $601 per month.
- Family of four with an income of $88,200, with one child age 7 to 12 the fee would be $1,027 per month (previously it would be $441 per month).

For parents currently paying a fee, the increase would be phased-in over three years. For parents of children who begin living in an out-of-home care arrangement after June 30, 2009, the full fee amount would be assessed.

This proposal would save $900,000 (General Fund) in 2009-10 and have an annual savings of $2.2 million (General Fund).

Background—Overview of Parental Fee Program. This program applies to parents of children under the age of 18 who live in any out-of-home arrangement. Parents are assessed a fee based on a sliding scale that varies by family income and family size. The fee is the same regardless of where the child is placed out-of-home.

The DDS determines the parents' ability to pay, assesses the fee and bills the parents on a monthly basis until the child turns 18 years. *Currently*, revenues generated by this program are deposited in the "Program Development Fund" and used for developing community-based resources.

Background—Overview of Family Cost Participation Program. This program, effective in 2005, requires Regional Centers to assess a share of the cost of respite, child day care, and camping services to parents who have a child *living at home* and *not* eligible for Medi-Cal. About 5,000 families are in the program. Families are informed of the number of units of service for which they are financially responsible and they pay this amount directly to the provider. About $4 million is saved annually under this program. The program was expanded in the Budget Act of 2008 to include all children aged 0 through 17 years, and the share of cost was adjusted.

Subcommittee Staff Comment and Recommendation. The DDS needs to clarify how this adjustment to the Parental Fee Program may affect the amount any family pays per child under the Family Cost Participation Program which is linked to the parental fee schedule within the Parental Fee Program.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **DDS**, Please explain the interaction with the Parental Fee Program and the Family Cost Participation Program
3. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

14. Consolidate Quality Assurance Evaluation (See Trailer Bill—Sections 4, 5, 6, and 8)

Summary of Proposal. Under this proposal, the existing Life Quality Assessment (LQA) and the evaluation of people with developmental disabilities moving from Developmental Centers into the community would be consolidated into a single quality assessment tool and data collection effort.

The DDS would still contract with the State Council on Developmental Disabilities to conduct surveys of consumers but on a much more limited basis. Information obtained from these surveys would then be used by the DDS and another contractor, operating under the direction of the DDS, to develop certain quality assurance performance and outcome indicators which are intended to do the following:

- Provide consistent and measurable data for DDS' "Quality Management System".
- Enable the DDS, Regional Centers and policy makers to benchmark the performance of California against that of other states, as well as a comparison of quality measures across all 21 Regional Centers.
- Provide a stratified, random sample of surveys among the entire DDS consumer population.
- Avoid the duplicative data collection of personal outcome elements (e.g., school, work, health, safety), currently generated by the Client Development and Evaluation Report.

This proposal would save $2 million (General Fund) in 2009-10 and have an annual savings of $2.2 million (General Fund). Most of this savings is derived from a reduction of reimbursements provided to the State Council.

This proposal requires trailer bill language and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program and administered by the DDS).

Subcommittee Staff Comment and Recommendation. A redesign of this process is warranted but this proposal needs further clarification regarding the use of data obtained from the surveys and the ability of the state to analyze a broader spectrum of outcome measures.

It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

Questions. The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

<u>15. First Use "Group Instruction" for Behavioral Instruction Prior to In-Home</u>
<u>(See Trailer Bill Hand Out—Section 3)</u>

<u>Summary of Proposal.</u> Under this proposal, expenditures for certain behavior intervention services would be redefined such that group instruction on behavior intervention for parents (or guardians) *must be* completed *prior* to receipt of in-home behavior services. Training would include the basics of behavior intervention, how to manage less severe behavioral challenges, and the role and responsibilities of parents (or guardians) in the provision of in-home behavioral services.

This proposal would save $8.1 million ($6.4 million General Fund) in 2009-10 and have an annual savings of $16.2 million ($12.8 million General Fund). The savings level assumes a six-month phase-in, and reflects a shift in service usage between the group trainings and the in-home behavior services.

The DDS states that training would be provided by a Board Certified Behavior Analyst with teaching experience and costs approximately $1,200 per training. For an averaged sized Regional Center, the assessed need is about 24 trainings per year.

This proposal requires trailer bill language and an amendment to the Home and Community-Based Waiver (under the Medi-Cal Program and administered by the DDS).

The DDS states that this proposal is a proven model of providing cost-effective behavior intervention services. Three Regional Centers (Valley Mountain, North Los Angeles, and Lanterman) provide group training to parents on behavior intervention.

<u>Background.</u> According to the DDS, Regional Centers spent $44.5 million (total funds) on in-home behavior services for consumers residing in their families homes. These expenditures include those services billed as "Client/Parent Support Behavior Intervention Training" and "Parent Coordinated Home Based Behavior Intervention Program for Autistic Children".

Behavior intervention services are often critical to a consumer remaining with their family at home.

<u>Subcommittee Staff Comment and Recommendation.</u> It is recommended to hold this issue "open" to clarify any remaining issues regarding the trailer bill legislation.

<u>Questions.</u> The Subcommittee has requested the DDS and applicable Workgroup participants to respond to the following questions.

1. **DDS**, Please provide a *brief* description of this proposal and its intent to achieve savings.
2. **Workgroup Participants**, Please provide comment where applicable, including any suggested changes to trailer bill language.

Additional Public Comment on All Issues (1 through 15)